WC-101 (R-8-04)

New Jersey Department of
Labor and Workforce Development
DIVISION OF WORKERS' COMPENSATION

NOTICE OF MOTION FOR TEMPORARY AND/OR MEDICAL BENEFITS (N.J.A.C. 12:235-5.2)

C.P. NO. _____

Vicinage_____

PETITIONER

SOCIAL SECURITY NUMBER:

NAME:

COUNTY OF RESIDENCE:
ADDRESS:

ATTORNEY FOR PETITIONER

FEDERAL EMPLOYER'S IDENTIFICATION NUMBER:
(If none, insert Social Security No.)

NAME:

ADDRESS:

TELEPHONE (Area Code)

VS

RESPONDENT

NAME:

COUNTY OF RESIDENCE:
ADDRESS:

INSURANCE CARRIER

NAME: (Indicate If Not Covered or Self-Insured):

CLAIM FILE NO.:
ADDRESS:

TO: _____
(Respondent's Attorney)

_____
(ADDRESS)

PLEASE TAKE NOTICE that the undersigned, Attorney for the Petitioner, will apply before the Presiding Judge of Compensation, at the District Office of the Division of Workers' Compensation referred to above, on the date to be fixed by the Division, for an Order pursuant to N.J.A.C. 12:235.2 compelling the Respondent or Respondent's insurance carrier to:

☐ 1. Pay to the Petitioner temporary disability benefits, from _____

to _____ or, _____ weeks at $ _____ per week, of which the Respondent has paid Petitioner for the following period:

from _____ to _____, or _____ weeks

at $ _____ per week.

☐ 2. Provide medical treatment for the Petitioner, and payment of the same, as the Petitioner (WAS) (IS) in urgent need of medical treatment. A copy of the Bill for services and report of Petitioner's treating physicians and/or institutions are attached hereto. The names of Petitioner's physicians and/or institutions are:

The Privacy Act, 5 U.S.C. § 552a, the Social Security Act, 42 U.S.C. § 405, and *N.J.S.A* 34:15-1 *et seq.* authorize the Division of Workers' Compensation to request that the Petitioner supply the Division with his or her Social Security number for record keeping purposes and cross-matches with the Social Security Administration, Workforce New Jersey, Temporary Disability Insurance and any other proper public purpose.

Dated: _____

_____
ATTORNEY FOR PETITIONER